Reset Form

CERTIFICATE OF VISION (EYE REFERRAL)

State Form 22106 (R6 / 4-19)
INDIANA BUREAU OF MOTOR VEHICLES

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Attn: Driver Ability Department
100 N Senate Ave RM N481
Indianapolis, IN 46204
Fax: 317-974-1614

INSTRUCTIONS:
1. *Complete in black or blue ink.*
2. *The Bureau of Motor Vehicles must complete Section A when a customer fails the original vision screening.*
3. *The customer must take this form to an Ophthalmologist or Optometrist to complete Section B – Certificate of Examination by Eye Doctor.*
4. *The customer must mail or fax the completed form to the Driver Ability Department after an Ophthalmologist or Optometrist completes Section B.*

SECTION A*: For License Branch Use Only.*

The attached certificate is for customer _____, CUID_____, for an evaluation of a potential vision condition. The BMV's basic vision screening indicates need for further examination. Optec 1000 BMV findings are as follows.

Acuity			**Glasses / Contacts**	**Examiner's Comments:**
Both	**Right**	**Left**		
20 /_____	20 /_____	20 /_____	☐ Yes ☐ No	

Date of Birth *(mm/dd/yyyy)*	Branch Number	By *(License Branch Associate)*	Date *(mm/dd/yyyy)*

SECTION B: Certificate of Examination by Eye Doctor (Ophthalmologist or Optometrist)

I have personally examined the listed named driver for visual conditions which might have direct bearing upon his or her qualifications to meet Indiana vision standards for driving.

Printed Name of Doctor	Business Telephone ( )	Date of Exam *(mm/dd/yyyy)*

Printed Name of Customer	Customer's Date of Birth *(mm/dd/yyyy)*	Customer's Telephone Number ( )

Without Lenses			**Wearing Best Possible Prescription**			If visual fields are less than 120 degrees in extent horizontally, attach copies of Goldmann III4e, Humphrey 120 point screen or equivalent fields.
Right Eye	**Left Eye**	**Both Eyes**	**Right Eye**	**Left Eye**	**Both Eyes**	Horizontal Diameter of Visual Fields
20 /_____	**20 /_____**	**20 /_____**	**20 /_____**	**20 /_____**	**20 /_____**	Right _____ Left_____

Diagnosis of visual condition(s), including estimate of stability, which could or may affect visual acuity, visual fields, or other aspects of vision.

Further vision loss is:	Prescription needed to achieve best corrected visual acuity:
☐ Unlikely ☐ Possible ☐ Likely	OD: OS:

Vision Requirements Chart *(Check one, if applicable.)*

☐ 1. One eye 20/40 or better, other eye 20/40 or better, unaided. No Restrictions	☐ 2. Best eye 20/40 or better, other eye 20/50 to blind, unaided. Outside Rearview Mirror Restriction	☐ 3. One eye 20/40 or better, other eye 20/40 or better, corrected with glasses or contact lenses. Corrective Lenses Restriction
☐ 4. Best eye 20/40 or better, other eye 20/50 through blind, corrected with glasses or contact lenses. Corrective Lenses Restriction and Outside Rearview Mirror Restrictions	☐ 5. One eye 20/50, other eye 20/50, corrected with glasses or contact lenses. Corrective Lenses Restriction	☐ 6. Best eye 20/50, other eye 20/70 to blind, corrected with glasses or contact lenses. Corrective Lenses, Outside Rearview Mirror, Daylight Driving Only Restrictions. *(We may ask for proof of normal peripheral visual fields.)*

☐ 7. One eye 20/70, other eye 20/70 to blind, corrected with glasses or contact lenses. Corrective Lenses, Outside Rearview Mirror, Daylight Driving Only Restrictions. *(Proof of normal peripheral visual fields must be attached. The visual fields test must be Goldmann III4e, Humphrey 120 point screen, or equivalent that is capable of testing at least 60 degrees temporally in each eye.)*

License valid only while wearing glasses or contact lenses when applicant requires the aid of glasses or contact lenses to pass Driver's License Vision Examination. Doctor must certify in writing if glasses will not improve vision.

Signature of Doctor	Typed or Printed Name of Doctor

Address *(number and street)*	City	State	ZIP Code

By signing, I authorize this information to be released to the Indiana Bureau of Motor Vehicles.

Signature of Driver	Printed Name of Driver	Date Signed *(mm/dd/yyyy)*